

EAP SUPERVISORY REFERRAL FORM

General Instructions: The purpose of this form is to provide information to the Employee Assistance Program (EAP) regarding an employee's poor work performance when there is reason to believe that the cause may be due to a personal-medical problem.

(PLEASE PRINT IN INK OR TYPE)

REFERRAL DATE: _____

EMPLOYEE'S NAME: _____

SS#: _____

STREET ADDRESS: _____

HOME PHONE: _____

CITY, STATE: _____

WORK PHONE: _____

ZIP: _____

DOB: _____

CLASSIFICATION: _____

GRADE: _____ EOD: _____

DEPARTMENT WORK LOCATION: _____

ADDRESS: _____

WORK HOURS (SHIFT): _____

DAYS OFF: _____

REFERRED BY: _____

TITLE: _____

PHONE NUMBER: _____

EAP COORDINATOR: _____

TITLE: _____

PHONE NUMBER: _____

EAP COORDINATOR'S SIGNATURE

REASON FOR REFERRAL

Please fill in the sections below that are relevant to this referral.

VIOLATION OF GOVERNOR'S EXECUTIVE ORDER REGARDING SUBSTANCE ABUSE

_____ Failed Random Drug Test.

_____ Alcohol related conviction

ATTENDANCE

_____ Number of days absent in past 12 months.

_____ Pattern (e.g., Mondays, Fridays, after paydays, before and after holidays).

_____ Number of extended lunch periods in past 6 mos.

_____ Number of times late in past 6 mos.

_____ Other: _____

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JOB PERFORMANCE

<input type="checkbox"/> Lower Quality of Work <input type="checkbox"/> Decreased Productivity <input type="checkbox"/> Increased Errors <input type="checkbox"/> Impaired Judgment/Memory	<input type="checkbox"/> Erratic Work Patterns <input type="checkbox"/> Failure to Meet Schedules <input type="checkbox"/> Inability to Concentrate <input type="checkbox"/> Other: _____
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BEHAVIOR DEMONSTRATED

<input type="checkbox"/> Avoids Supervisors or Co-workers <input type="checkbox"/> Less Communicative <input type="checkbox"/> Unusually Sensitive to Advice or Constructive Criticism <input type="checkbox"/> Unusually critical of supervisor, co-workers or Employer	<input type="checkbox"/> Loss of Interest <input type="checkbox"/> Frequent Mood Swings <input type="checkbox"/> Disregard for Safety <input type="checkbox"/> Other: _____ _____
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HAVE THE ABOVE ISSUES BEEN DISCUSSED WITH THE EMPLOYEE? ____ YES ____ NO

HAS THE EMPLOYEE BEEN REFERRED TO THE STATE MEDICAL DIRECTOR? ____ YES ____ NO
IF YES, WHEN? _____ (Please attach all relevant documentation)

THIS SECTION MUST BE COMPLETED BY THE EMPLOYEE

I understand that my employer is referring me to the State's Employee Assistance Program (EAP). I also understand that my signature below does not reflect my agreement/disagreement to any of the issues raised. My signature verifies that I have seen the referral and all documentation contained therein.

☐ YES, I will participate in the Employee Assistance Program.
My health insurance carrier is: _____

☐ NO, I will not participate in the Employee Assistance Program.

SIGNATURE

DATE

Please forward the MS 561 and all supporting documentation in **DUPLICATE** to:

Maryland Department of Budget & Management
Office of Personnel Services and Benefits
Employee Assistance Program
301 W. Preston Street, Rm. 607
Baltimore, Md. 21201

If you have a question, call the Employee Assistance Program on 410-767-1012.

***FAILURE TO FULLY COMPLETE THIS FORM WILL RESULT IN A DELAY IN YOUR APPOINTMENT**

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